AMERICA'S ESSENTIAL HOSPITALS

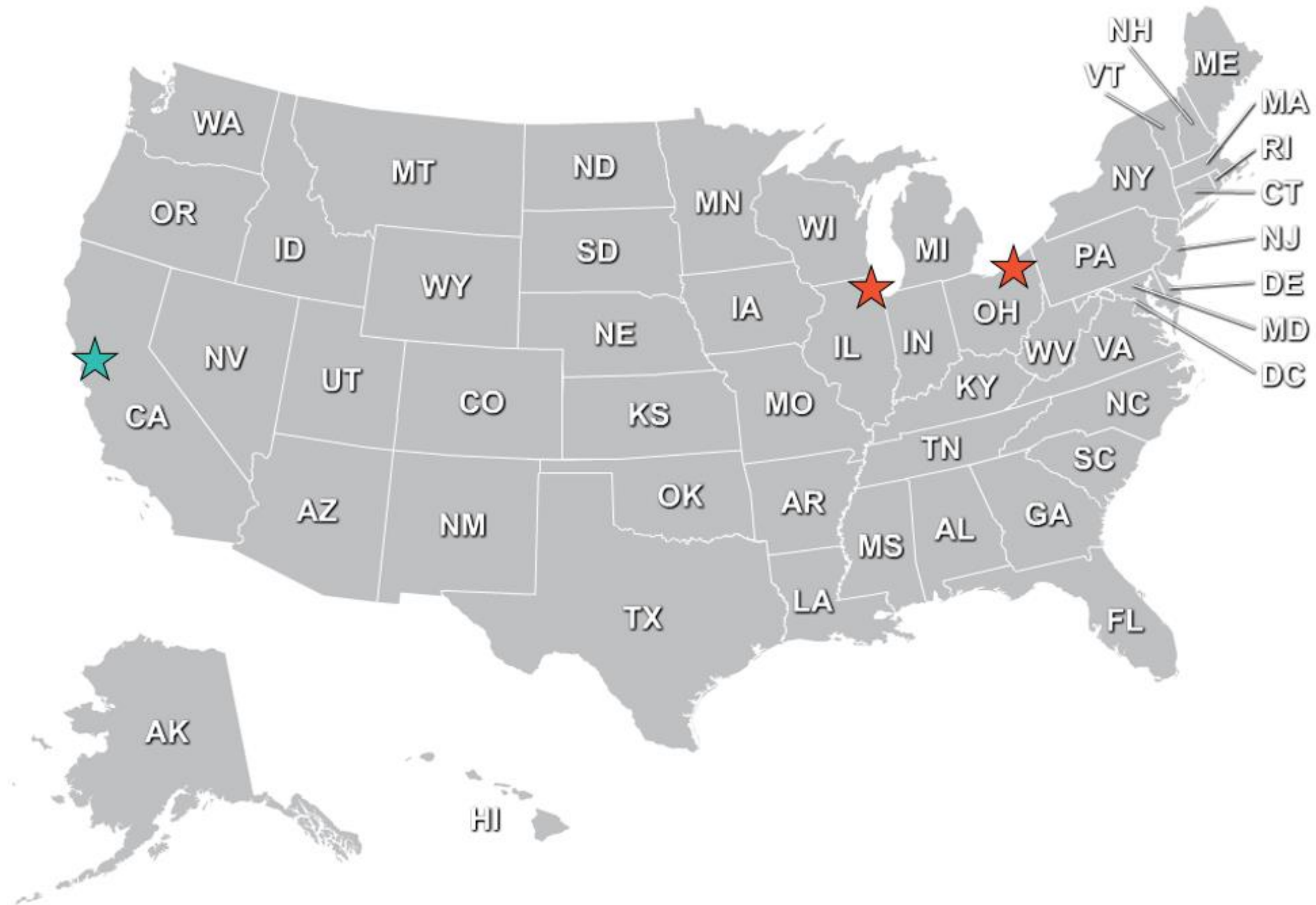
# Local Coverage Expansion, Private Option Waivers, and DSRIPs

# AGENDA

- Overview
- Local Coverage Expansion
- Private Option Waivers
- Delivery System Reform Incentive Programs (DSRIPs)
- Questions

# Local Coverage Expansion

# LOCAL COVERAGE EXPANSION



# CUYAHOGA COUNTY (OH) AND COOK COUNTY (IL)

MetroHealth Care Plus & County Care

- Early Medicaid expansion
- Through an 1115 waiver
- Funded by county and/or public hospital using money that would have been spent on the uninsured and/or uncompensated care
- Covered 19 to 64 year olds with incomes up to 133% of the FPL
- Led by the public hospital; included FQHCs within network

# CITY AND COUNTY OF SAN FRANCISCO (CA)

Healthy San Francisco

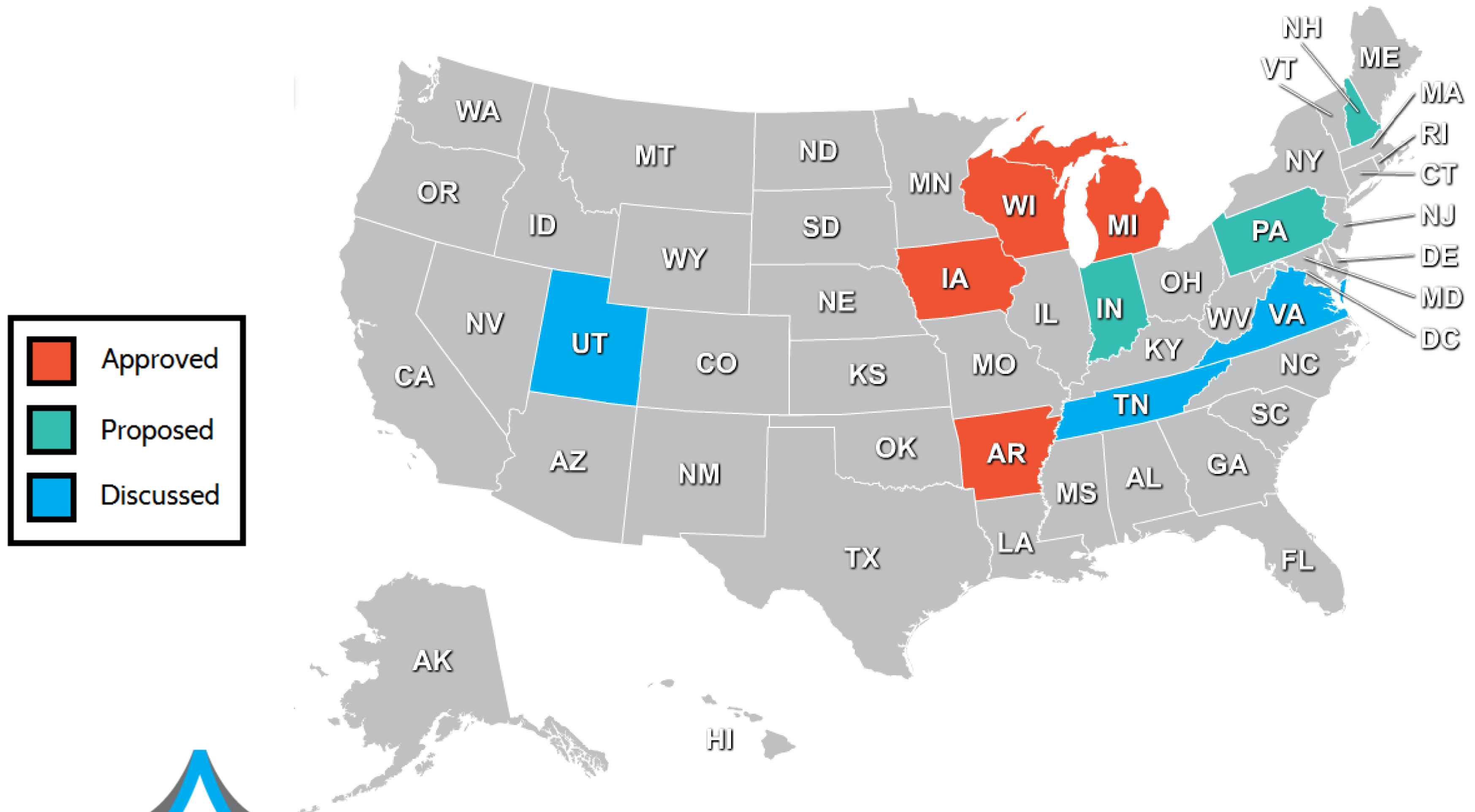
- Pre-ACA
- Authorized by local legislation
- Funded by City and County of San Francisco, State of California, and employers
- Covers uninsured residents up to 500% of the FPL; must be uninsured for at least 90 days
- Led by Department of Public Health, which runs the public hospital; included CHCs within network

# ISSUES TO CONSIDER

- Eligible population
  - Uninsured (including those that could be newly eligible for Medicaid) or some subset of the uninsured?
- Benefit design
  - Medicaid equivalent? EHB equivalent? Something else?
- Provider network
  - Closed or open?
- Funding source
  - Local and/or state only? State with federal match?
- Authorization
  - 1115 waiver? State legislation?

# Private Option Waivers

# PRIVATE OPTION WAIVERS



# PRIVATE OPTION WAIVERS

- "ACA expansion with a twist"
- Approved in Arkansas, Iowa, Michigan, and Wisconsin
- Proposed in Indiana, New Hampshire, and Pennsylvania
- Discussed in Tennessee, Virginia, and Utah but proponents face tough political environments in these states

# ARKANSAS, IOWA, MICHIGAN, WISCONSIN

- Partial Medicaid expansion through private and/or Medicaid managed care
  - » AR: childless adults (0-138% of the FPL) and parents (17-138% of the FPL)
    - Through QHPs on the exchange
  - » IA: non-medically frail adults (101-138% of the FPL)
    - Through QHPs on the exchange
    - Those with incomes below 101% of the FPL are in Medicaid managed care
  - » MI: childless adults (0-138% of the FPL)
    - Through Medicaid managed care
  - » WI: childless adults (0-100% of the FPL)
    - Through Medicaid managed care

# ARKANSAS, IOWA, MICHIGAN, WISCONSIN

- States provide premium assistance so that expansion population can buy coverage

  - » AR: beneficiaries not responsible for premium
    - No cost sharing for those below 100% of the FPL; Medicaid and exchange rules around cost sharing apply for those between 100-138% of the FPL
    - Seeking approval to require HSA contribution for those above 50% of the FPL

  - » IA: beneficiaries begin to pay premium in year two unless they complete specified health improvement activities
    - Copay required for non-emergency use of ED

# ARKANSAS, IOWA, MICHIGAN, WISCONSIN

- MI: beneficiaries above 100% of the FPL pay premiums equal to 2% of income and contribute 2% to health account based on their FPL for an individual; all beneficiaries will pay a monthly copay amount to health account based on prior six months of copay utilization; cost sharing reduced if they achieve specified healthy behaviors

- WI: n/a

# ARKANSAS, IOWA, MICHIGAN, WISCONSIN

- States provide wrap-around coverage for Medicaid benefits
  - » AR: non-emergency transportation, EPSDT for 19 and 20 year olds, out of network family planning
    - Seeking approval to limit non-emergency transportation for the non-medically frail
  - » IA: EPSDT (non-emergency transportation waived for one year)
  - » MI: n/a
  - » WI: n/a

# INDIANA, NEW HAMPSHIRE, PENNSYLVANIA

- Partial Medicaid expansion through private and/or Medicaid managed care

  » IN: non-disabled adults (0-138% of the FPL)
    - Through Healthy Indiana Plan 2.0 (private high deductible plan + personal wellness and responsibility (POWER) account); also through employer-sponsored coverage, if available

  » NH: newly-eligible adults (0-138% of the FPL)
    - Through Medicaid initially, shifting to private option beginning in 2016; also through employer-sponsored coverage, if available

  » PA: childless adults (0-138% of the FPL) & parents (33-138% of the FPL)
    - Through exchange or other private insurance options

# INDIANA, NEW HAMPSHIRE, PENNSYLVANIA

- States provide premium assistance so that expansion population can buy coverage
  - » IN: all beneficiaries contribute a flat fee based on a sliding scale to POWER account; POWER account is initially valued at $1,100/pp to pay for deductibles; those below 100% of the FPL who fail to contribute will receive a lesser benefit package (e.g., limited Rx, higher copay, etc.) and those above 100% will be locked out for 6 months after a 60 day grace period; separate copay for nonemergency use of ED
  - » NH: no detail yet for private option premium or cost sharing obligations
  - » PA: beneficiaries above 100% of the FPL begin to pay premiums based on a sliding scale in year two; premiums reduced if they engage in specified healthy behaviors and meet work requirements; state covers cost sharing for in-network QHP benefits

# INDIANA, NEW HAMPSHIRE, PENNSYLVANIA

- States provide wrap-around coverage for Medicaid benefits
  - » IN: EPSDT for children
  - » NH: facilitation and care coordination services (Medicaid); no detail yet for the private option
  - » PA: seeking to waive all wrap-around coverage

# TENNESSEE, VIRGINIA, UTAH

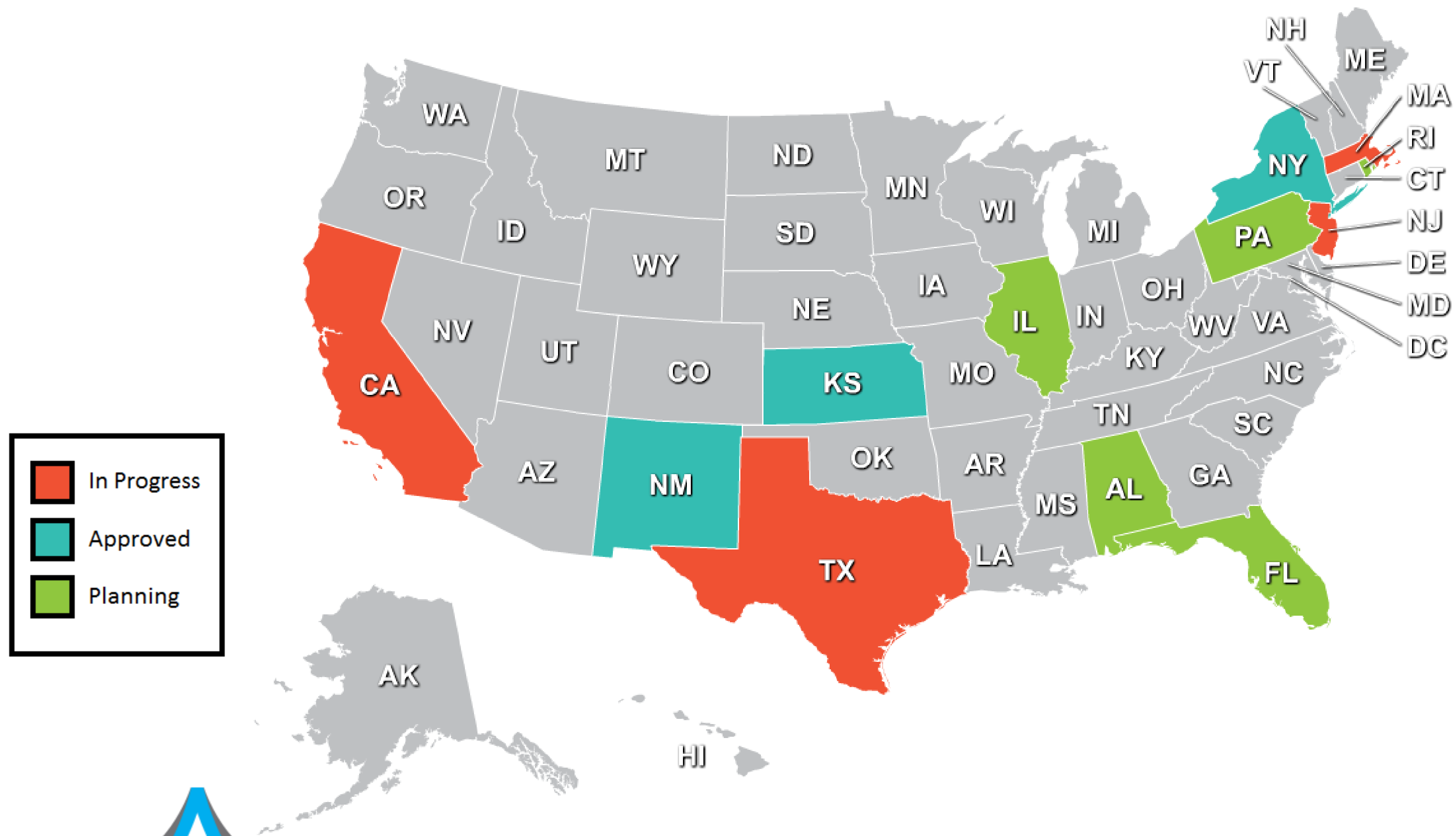
- TN: governor wants to expand Medicaid through private option for those up to 138% of the FPL
  - Wants to promote healthy behaviors (through incentives via HSA) and consumer engagement in healthcare utilization (through copay structure and amount); also wants to pay providers based on outcomes
- VA: senate wants to expand Medicaid through private option with consumer cost sharing and job search requirements; house continues to reject expansion in any form; and governor wants ACA expansion
- UT: governor wants the money that would have been given to UT if UT took the ACA option to expand, as a block grant, to support a 3 year pilot that would assist those making under $15,000/year to purchase private coverage

# ISSUES TO CONSIDER

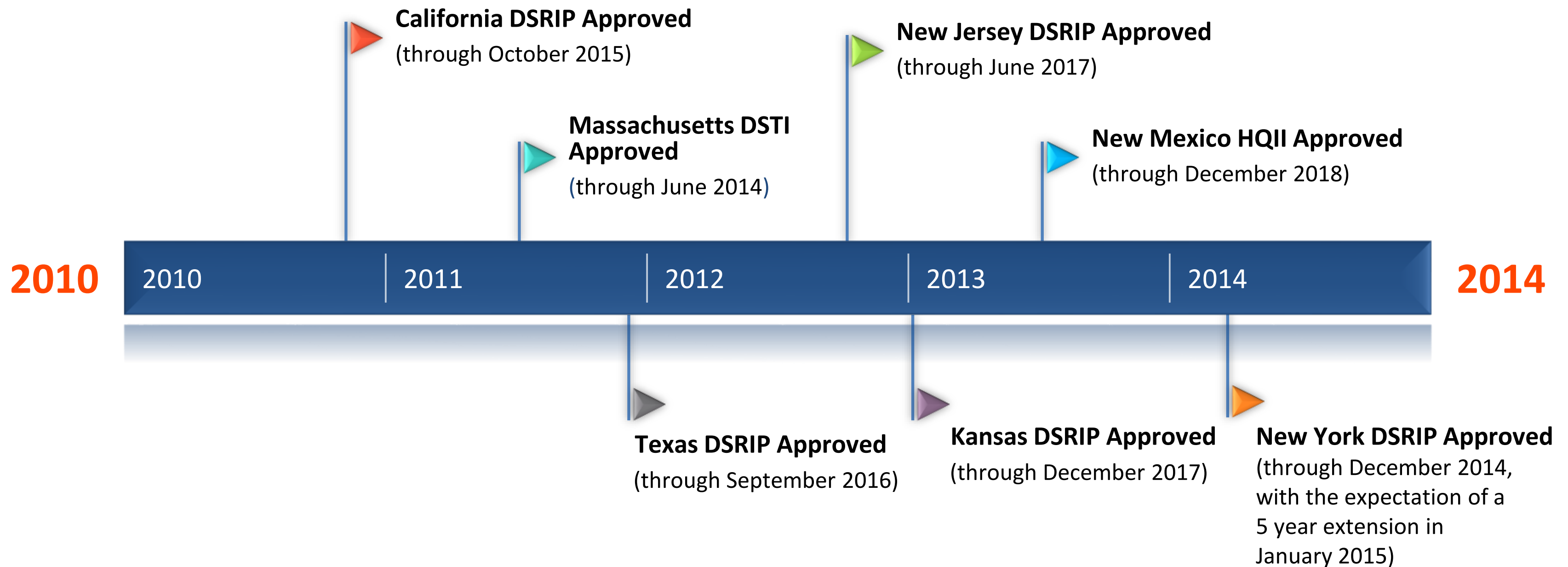
- Eligible population
  - » Everyone up to 138% of the FPL or a subset?
- Benefits
  - » EHB with wraparound or Medicaid?
- Provider network
  - » QHP or Medicaid?
- Beneficiary obligation
  - » Premium, copay, health savings account?
- Authorization
  - » 1115 waiver? State legislation?

# DSRIPs

# DSRIP ACTIVITY



# DSRIP ACTIVITY TIMELINE



# DSRIP TRENDS

- Not a payment for services

- Purpose must be aligned with state goals
- Projects tend to focus on:
  - » Infrastructure building, innovation and redesign, quality and outcome improvement, population health, reducing harm, getting ready for alternative payment models/risk
- Success depends on non-hospital and non-provider partners
- Design is becoming more formulaic
- Lessons learned is shared through formal collaboratives
- Less new money, more repurposed funds

# ISSUES TO CONSIDER

- Who determines success?
  - What goals will you tackle and which projects will you work on?
- How sustainable are the incentives?
  - What happens if performance tops out and the option is no longer available? What happens if your perform ance isn't up to par?
- How do you manage if existing funds for patient care is repurposed for DSRIPs?
- How do you manage relationships with outside providers and non-providers?
- How do you manage/motivate your staff to tackle yet another project?
- Will you be ready to accept more risk?